



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 30, 2026

Administrator

Laurels Peak Care & Rehabilitation Center

700 JAMES AVENUE

MANKATO, MN 56001

RE: CCN: 245516

Cycle Start Date: January 6, 2026

Dear Administrator:

On January 6, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated

under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 6, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an

explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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Administrator
Laurels Peak Care & Rehabilitation Center
700 JAMES AVENUE
MANKATO, MN 56001

Re: Event ID: 1DFEE1-H1

Dear Administrator:

The above facility survey was completed on January 6, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245516	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Laurels Peak Care & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 700 JAMES AVENUE , MANKATO, Minnesota, 56001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 1/6/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H55161340C (2692887) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review the facility failed to ensure all staff were competent with transferring and walking residents that required transfer assistance for 1 of 3 residents (R1). This deficient practice resulted in R1 falling and fracturing the facial bone. The facility had put corrective measure in place, prior to the start of the survey and therefore, this was issued at past non-compliance.	F0689	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0689 SS = G	<p>Continued from page 1</p> <p>Findings include:</p> <p>R1's face sheet dated 1/6/26, identified diagnoses of respiratory failure, atrial fibrillation (irregular heart rhythm), osteoporosis, and other variants of Turners Syndrome (condition that affects only females, results when one of the X chromosomes (sex chromosomes) is missing or partially missing. Turner syndrome can cause a variety of medical and developmental problems, including short height, failure of the ovaries to develop and heart defects.), and disorientation.</p> <p>R1's admission Minimum Data Set (MDS) dated 12/5/25, identified R1 had no issues with hearing or speech, no cognition issues, no behaviors or rejection of care, used a walker, partial assist with toileting hygiene, lower body dressing, supervision with upper body dressing, supervision with sit to stand, chair/bed transfer, and walk 50 feet with two turns. R1 had a fall in the month prior to admission but no falls since admission.</p> <p>R1's care plan dated 12/2/25, identified interventions to follow physical therapy (PT) and occupational therapy (OT) for mobility function. Toileting with stand by assistance and R1 was to ambulate to the bathroom with front wheeled walker (FWW) and toilet self with staff present but providing only encouragement; transfer with stand by assist and use FWW- staff to provide encouragement training in hallway without assistive device. R1 demonstrated mild loss of balance but able to recover independently. R1 demonstrated an inconsistent gait path and had a tendency to wander throughout hallway. Ambulated with FWW in hallway with noted improvement in stability. Educated on current continued use of FWW recommendation. R1 remained appropriate for use of FWW.</p> <p>Nursing Home Incident Report (NHIR) submitted to the State Agency on 12/12/25 at 10:23 a.m., identified R1 requested to walk for walking program. Nursing assistant (NA)-A was walking with resident, when resident fell and hit her head. R1 was transported to the emergency department (ED) for evaluation with physical injuries noted of bruising above right eye, nosebleed, and hematoma (collection of blood outside of a blood vessel) to right side of head.</p> <p>R1's progress note dated 12/13/25 at 7:38 a.m., identified on 12/12/25, R1 was lying on her back on the floor. Right eyelid bruised and swollen shut. Hematoma to right side of forehead and bloody nose. R1 stated she was walking without her walker and fell forward</p>	F0689		

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F0689 SS = G	<p>Continued from page 2 hitting her face. R1 had an ice pack applied to her face and was sent to ED for evaluation as she took blood thinning medication.</p> <p>R1's hospital discharge summary dated 12/13/25, identified R1 had a closed facial bone fracture, spent the night at the hospital, and returned to facility on 12/13/25, follow-up visits scheduled with neurosurgery and head computed tomography (CT).</p> <p>R1's progress note dated 12/15/25 at 11:19 a.m., identified R1 had been downgraded to assist of one staff using FWW and gait belt due to recent fall, care plan and Kardex updated.</p> <p>R1's progress note dated 12/19/25 at 10:51 a.m., identified R1 had new therapy orders to walk to all meals with FWW and gait belt, assist of one to follow with wheelchair, care plan and Kardex updated.</p> <p>R1's care plan was updated on 12/16/25, and identified education provided to staff to utilize appropriate devices during mobility; on 12/19/25 walk to all meals with FWW and gait belt, wheelchair to follow, with assist of one staff member.</p> <p>During an observation and interview on 1/6/26 at 10:13 a.m., R1 was in a wheelchair with visible bruising under both eyes, had a visitor in the room; the visitor was leaving and R1 stood up from the wheelchair and hugged the visitor and sat back down in the wheelchair. R1 stated on 12/12/25, NA-A came into the room and put a gait belt on her. R1 stated she watched NA-A struggle to put the gait belt on. R1 did not recall taking her walker with when they went on the walk. "she should have made sure I had my walker". R1 stated NA-A was not holding the gait belt during the walk and R1 was turning a corner and "just went down, it was a very traumatic fall". R1 ended up in the hospital with blood behind her brain, a brain bleed, but was unsure if she had a fracture. R1 stated she did not get dizzy or lose her balance prior to the fall. All the other staff have used the gait belt and walker properly. R1 was updated by facility that all staff would have training on using proper equipment with residents. R1 stated she had just had her follow-up neurology appointment, and the CT scan showed no more bleeding in the brain.</p> <p>During a phone interview on 1/6/26 at 1:17 p.m., NA-A stated she is a per diem (as needed) employee and worked at the facility when shifts were available. The facility had encouraged staff to come in and read care plans, but sometimes care plans were read when there was time. On 12/12/25 she was working on R1's wing and</p>	F0689		

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F0689 SS = G	<p>Continued from page 3</p> <p>that was the second shift she had worked with her. NA-A indicated R1 was self-directed and she had been told by other staff to let R1 do what she wanted to do and to stand-by and watch. R1 put on her bathroom call light around 10:10 a.m. or 10:15 a.m. NA-A responded to the light and found R1 in the bathroom with no walker and no gait belt on. R1 told NA-A she had walked to the bathroom by herself. NA-A assisted R1 to clean up in the bathroom, and R1 walked out of the bathroom without assistance and her walker then sat in her wheelchair. R1 stated she wanted to take a walk (in the hallway). NA-A asked if R1 wanted to use her front wheeled walker and NA-A would push the wheelchair behind her, R1 declined. NA-A stated she applied the gait belt around R1's waist. When R1 stood up and NA-A attempted to hold the gait belt, R1 told NA-A "NO I can do it!". NA-A followed R1 as she walked from her room to the entrance of therapy, that is where they turned. NA-A stated there was a dip in the floor, R1 mis-stepped which caused R1 to fall forward very fast. NA-A reiterated that she had taken her time and even read R1's care plan but given R1's refusal of all the "crutches" she offered, she respected R1's wishes. R1 wanted to do everything herself.</p> <p>During an interview on 1/6/26 at 1:47 p.m., nurse manager (NM)-A stated on 12/12/25, she came from a meeting to assist R1 off the floor. The nurse practitioner was onsite and examined R1 and gave an order to send her to the ED. R1 was able to move all extremities and verbalized what happened. NM-A applied ice to R1's face while they waited for the ambulance to arrive. NM-A is part of the IDT and is involved with fall prevention and interventions after a fall occurs. The root cause of R1's fall was R1 refused to use her FWW and NA-A let R1 inappropriately walk without assistive devices.</p> <p>During an interview on 1/6/26 at 10:21 a.m., director of rehabilitation services (DOR)-A stated R1's level of function prior to admitting at the facility was not using assistive devices and therapy was working to get R1 independent with the FWW. By 12/12/25, therapy had been working with R1 to walk without her walker, going short distances to build up endurance. R1 was not safe to walk 100 feet without her walker, she would fatigue and lose her balance. The week of 12/12/25, therapy had talked with R1 about being independent in her room and not needing to use her walker, but not that she could walk in the hallways unassisted. DOR-A stated on 12/12/25, she was called out of a meeting around 10:30 a.m., due to R1 falling on the ground. DOR-A assisted the NM-A and a NA to use a mechanical lift to move R1 from the floor to the wheelchair. When R1 returned on</p>	F0689		

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F0689 SS = G	<p>Continued from page 4 12/13/25, she was assist of one with all activities and had a fear using less assistance from staff. By 12/30/25, R1 was a stand-by assist in her room with FWW, and on 1/5/26, she was able to be independent in her room with FWW. After falls, the Interdisciplinary Team (IDT) works together to come up with appropriate interventions.</p> <p>During a phone interview on 1/6/26 at 1:59 p.m., medical doctor (MD)-A stated one of the biggest risk factors of a fall would be a fracture and brain bleed but there could be lots of minor injuries also that would set back therapy as well. Anyone that has a brain bleed the doctor needs to be cognizant about anticoagulation and repeated falls, where the brain bleed is at, how much of the brain is bleeding, and what it will affect. Orbital fractures, such as what R1 was diagnosed with, staff should watch for more pain and headaches, and that could reduce therapy time and take longer to reach her goals. MD-A reviewed R1's hospital chart and stated R1 had a telephone visit with neurology on 1/6/26, to discuss the CT that was completed 1/5/26 and It did not look like they thought much of the injuries. Falls are discussed at the facility Quality Assurance Performance Improvement (QAPI) meetings. MD-A is notified of any falls with injuries, or that require hospital or ED visits.</p> <p>During an interview on 1/6/26 at 2:51 p.m., Administrator stated for audits the nurse management staff would observe staff and residents completing the tasks of walking and transfers to make sure it was done correctly; after the observation they would review with staff what to do if a resident would refuse to use an assistive device, and where they would locate the information on each resident to know what devices they utilized. The facility investigation revealed it was a one-time occurrence, and that staff member is no longer employed at the facility. An audit on all resident Kardex's was also completed to make sure all residents information was current and up to date. Staff should always follow the care plans and Kardex. Reviewed with Administrator the corrective actions taken by the facility to correct the deficient practice and the dates they were completed.</p> <p>The deficient practice was issued at past non-compliance after the following corrective actions were implemented, and verified the facility took the following actions, prior to the start of the survey:</p> <p>-NA-A was suspended on 12/12/25, and resigned from her position on 12/12/25.</p>	F0689		

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F0689 SS = G	<p>Continued from page 5</p> <ul style="list-style-type: none"> -updated R1's care plan on 12/16/25, and ongoing as needed. -reviewed and updated as needed all residents care plans on 12/16/25. -education on ambulation began on 12/16/25 and will be ongoing -education on following care plans/Kardex began on 12/16/25 and will be ongoing. -audits to ensure staff are aware of following care plans and what to do if a resident refuses to utilize appropriate devices began 12/16/25 and will be ongoing. -PHQ-9 and trauma assessments completed 12/16/25. -R1 continues to work with therapy on ambulation and independence to return to community setting. <p>The facility Fall Prevention and Management policy updated 11/2025, identified nursing staff will begin to try to identify possible or likely causes of the incident and evaluate the chain of events or circumstances preceding a recent fall. The IDT will review falls daily at morning meeting and care plans will be updated to reflect fall interventions.</p> <p>The facility Safe Resident Handling Program policy updated 11/2025, identified the policy was to protect the health and comfort of residents and staff when residents require assistance in moving through the consistent use of mechanical aides/devices. Gait belts must be used for ambulatory residents when indicated in the care plan to allow employees to hold onto the belt to provide support and stabilize the resident when walking. Training of nurses and other direct care employees will be provided to demonstrate proper application and use of available safe patient handling equipment.</p>	F0689		

Minnesota State Department of Health

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 1/6/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed during the survey: H55161340C (2692887). No orders were issued.</p>	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		